BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	
MARIA EUGENIA COLLIO	Case No. 2006-222
	OAH No. L2006060573
Registered Nurse License No. 555992	
Respondent.	

ORDER DENYING RECONSIDERATION

Respondent's request for reconsideration of the decision heretofore made and herein having been read and considered, and determination made that good cause for the granting of reconsideration has not been established, reconsideration of said Decision is hereby denied. The Board's Decision issued on August 28, 2007, becomes effective on September 28, 2007.

IT IS SO ORDERED this 27th day of September 2007.

BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

LaFrancine Tate
Board President

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Statement of Issues Against: MARIA EUGENIA COLLIO, Respondent.	Case No.: 2006-222 OAH No.: L2006060573

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Board of Registered Nursing as its Decision in the above-entitled matter.

This Decision shall become effective September 28, 2007.

IT IS SO ORDERED August 28th 2007.

BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By LaFrancene W Tate

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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MARIA EUGENIA COLLIO 2161 25th Street, Apt. 1 San Pedro, California 90732, Registered Nurse's License No. 555992, Respondent.	Case No. 2006-222 OAH No. L-2006060573

PROPOSED DECISION

This matter was heard by Vincent Nafarrete, Administrative Law Judge of the Office of Administrative Hearings, in Los Angeles on March 21 - 23, 2007, and May 21, 2007. Complainant was represented by Anne Hunter, Deputy Attorney General. Respondent Maria Eugenia Collio was present and represented by Frederick M. Ray, Attorney at Law.

Oral and documentary evidence having been received and the matter submitted for decision on May 21, 2007, the Administrative Law Judge finds as follows:

FACTUAL FINDINGS

1. On or about June 23, 1999, the Board of Registered Nursing issued registered nurse's license no. 555992 and licensing rights to Maria Eugenia Collio (hereinafter respondent). Said license will expire on July 31, 2007, unless renewed, and is in full force and effect. Respondent has no prior disciplinary history on her nursing license.

2. (A) Respondent has been a licensed registered nurse for eight years and has no history of disciplinary action on her nursing license. She was born in Chile in 1953. She attained a bachelor of science degree in midwifery from the University of Chile in 1979. Thereafter, respondent worked in Chile as a midwife with a hospital neonatology unit for two years and with a public health and family planning agency for another two years. From 1984 through 1987, she worked as a midwife at a hospital in Brazil.

(B) In 1987, respondent came to the United States. For three years, she worked a certified nursing assistant in Torrance. In 1991, she obtained licensure as a

licensed vocational nurse (LVN) and then worked as a LVN in Garden Grove and for Interim Health Care in Long Beach. In 1998, she was named nurse of the year by Interim Health Care. While working as a LVN, respondent attended additional nursing classes at Harbor College. In 1999, she attained her registered nurse's license. She first worked as a registered nurse at the El Monte Medical Center for one year and then was hired for the labor and delivery unit at the St. Mary Medical Center (also hospital) in Long Beach in 2000.

3. (A) In February 2004, respondent was terminated from her nursing employment at St. Mary hospital due to her nursing care in connection with the labor and delivery of a stillborn fetus in January 2004. Respondent's nursing care of the patient and fetus are the subject of the instant accusation.

(B) On January 17, 2004, St. Mary Medical Center reported the stillborn death of an infant to the Los Angeles County Coroner's office. An coroner's investigator obtained partial medical records and statements of witnesses. In a report dated January 28, 2004, the coroner's investigation noted that the mother or patient was in good health and began having a fever about 30 minutes before going to the hospital emergency room. An emergency Cesarean section was performed after the fetus became bradycardic. The coroner's investigator also noted that cultures of the mother's blood, placenta, and gastric aspirate developed Staphylococcal aureus.

(C) In or about April 2004, the hospital hired a perinatal nurse consultant to evaluate the case. The nurse consultant reviewed medical records and information from a grievance hearing. In an opinion letter dated April 14, 2004, the nurse consultant concluded that respondent had failed to meet the standard of care in the care of the patient assigned to her in the labor and delivery unit on January 16-17, 2004. The nurse consultant found respondent failed to appropriately utilize basic nursing process, to assess and interpret the fetal heart rate and pattern, and to intervene. The nurse consultant concluded that respondent's failures led to the "catastrophic stillbirth of a full-term, infant boy." After an attempted Cesarean section delivery, the stillborn infant was found to have the cord around his neck. In the judgment of the nurse consultant, cord compression and "fetal jeopardy" occurred during "a prolonged epidural procedure" from which the infant was unable to recover. The nurse consultant concluded that respondent's failures to meet the standard of care for a high risk fetus, including communication with the physician, contributed to the stillbirth and constituted gross negligence and incompetence.

(D) On May 28, 2004, the chief nursing executive of St. Mary hospital filed a complaint with the Board of Registered Nursing, asserting that respondent had committed gross negligence and incompetence. The chief nursing executive attached to the complaint an opinion letter and record review prepared by the perinatal nurse consultant. A senior investigator from the Division of Investigation, Department of Consumer Affairs, obtained medical and other records, spoke with the perinatal nurse consultant, interviewed respondent, and prepared an investigative report with attachments dated April 6, 2005.

(E) On July 15, 2004, a deputy medical examiner of the Los Angeles County Coroner's office issued an Autopsy Report describing his findings from an autopsy performed six months earlier. The deputy medical examiner noted that, after showing signs of bradycardia, the 38-week old male fetus was delivered stillborn by Cesarean section to the patient who was admitted to the hospital with fever and spontaneous rupture of the membranes. Hospital blood culture, placenta culture, and fetal gastric aspirate tested positive for "staph aureus." The deputy medical examiner ascribed the intrauterine fetal death to fetal sepsis arising from maternal sepsis which was caused by Staphylococcus aureus.

4. In or about October 2005, respondent was reinstated as a pier diem nurse with her seniority rights at St. Mary Medical Center. On March 17, 2006, the chief nursing officer at St. Mary Medical Center hospital advised the Board that the hospital had reinstated respondent after reviewing "new information regarding the facts leading to her termination."

5. (A) On May 16, 2006, the Accusation, Case No. 2006-222, was made and filed by complainant Ruth Ann Terry, M.P.H., R.N., in her official capacity as Executive Director, Board of Registered Nursing, Department of Consumer Affairs, State of California (hereinafter Board). The Board has alleged that respondent was grossly negligent and/or incompetent in carrying out her nursing functions and duties in connection with the labor and delivery of a patient.

(B) On May 25, 2006, the Accusation and pertinent documents and forms required by the Government Code were served upon respondent at her address of record. On or about June 12, 2006, respondent filed a Notice of Defense, acknowledging receipt of the Accusation and requesting a hearing to allow her to present a defense to the charges. Subsequently, respondent was properly served with notices of hearing. Jurisdiction exists in this matter.

Patient A—January 16, 2004

6. (A) On January 16, 2004, at approximately 9:00 p.m., patient A (hereinafter patient) came to the emergency room at St. Mary Medical Center with her husband. She was 38 weeks pregnant and in active labor. The patient also complained about having recently developed a fever. Her obstetrician and physician was Dr. Bertram E. Sohl, who had been providing her with prenatal care at the public health department and then recently at the St. Mary obstetrics clinic.

(B) At approximately 9:30 p.m., patient had a spontaneous rupture of her membranes and was transferred from the emergency room to the labor and delivery unit. The patient was admitted to a labor and delivery room and assigned to respondent's care. At approximately 10:02 p.m., respondent placed the patient on a fetal heart rate (FHR) monitor. Tracing began immediately and showed that the FHR was reassuring at 140-150 with average long-term variability. The patient was having contractions every four minutes.

Respondent assessed the patient by taking her vital signs and performing a vaginal examination. She took the patient's history. The patient had a low-grade temperature of 99.8. Her pulse was 104. She was dilated to two centimeters and her amniotic fluid was clear. She was in the early stage of labor. Respondent documented her initial assessment on the Obstetrical Assessment Form, noting that the assessment was completed at 10:50 p.m.

7. (A) At 10:22 p.m., respondent started an IV fluid bolus in the patient's left arm. At 10:30 p.m., the patient's contractions were two to three minutes apart and lasted one to one and one-half minutes, indicative of a good uterine contraction pattern and a change to the cervix.

(B) At 10:27 p.m., the FHR monitor showed evidence of a late deceleration. At 10:33 p.m., there was another instance of a late deceleration. At 10:37 p.m., the baseline of the FHR also increased to 170 which was indicative of tachycardia. Respondent did not necessarily identify or note the late decelerations or tachycardia.

(C) At 10:48 p.m., the patient's temperature had risen to 102 degrees. Respondent administered a Tylenol suppository to the patient for her fever and noted the administration on the FHR monitor strip. She did not document the administration of the Tylenol on the Medication Administration Record. When she gave the Tylenol to the patient, respondent had not yet spoken with the physician or received a physician order for the medication.

(D) At 10:50 p.m., when the patient's temperature was noted at 102 degrees and after administration of the Tylenol, the baseline of the FHR increased to 180-190. The FHR had been tachycardic for more than ten minutes, which was indicative of possible fetal distress and a change in the risk or normalcy of the pregnancy.

8. (A) At 10:50 p.m., respondent first called the patient's physician, Dr. Sohl. She reported to Dr. Sohl that the patient's amniotic fluid was clear, fetal monitoring was reactive, and her labor pattern was good. Respondent further reported that the patient had a temperature.

(B) At 10:50 p.m., Dr. Sohl gave physician orders to respondent that the patient receive continuous monitoring. The physician ordered intravenous hydration, Tylenol suppository, and the antibiotic Ampicillin intravenously for the patient. The doctor also ordered that blood cultures with a complete blood count and urine culture be taken for laboratory analysis. Dr. Sohl ordered that the patient could receive Pitocin as needed and may have an epidural. Respondent documented Dr. Sohl's orders on the physician order form and in the nursing notes. She did not express, however, any concerns about the tachycardic nature of the FHR or the condition of the patient or fetus.

9. (A) After receiving the physician orders, respondent called for laboratory personnel to perform draws for the blood cultures and ordered the Ampicillin from the hospital pharmacy. The patient's blood was then drawn at 11:28 p.m. Respondent inserted a

Foley catheter into the patient's bladder and collected a urine sample herself from the patient for urinalysis at 11:43 p.m.

(B) At 11:00 p.m., respondent charted in the nursing flow chart that the FHR was 180 to 190 with average variability. At 11:30 p.m., she charted that the FHR increased to 190 to 200 with average variability. The FHR monitoring strip showed, however, that beginning at 11:10 p.m. and continuing thereafter, the baseline of the FHR began fluctuating between 180 and 200. The FHR baseline exhibited minimal long term variability and a non-reassuring sinusoidal pattern indicative of fetal distress. Respondent did not recognize or chart this change in the status of the patient and fetus and did not notify the physician of the change.

(C) At 11:43 p.m., the patient's temperature had risen to 103 degrees. At 11:52 p.m., which was one hour after the physician order for the antibiotic, respondent administered the Ampicillin to the patient by "IV piggyback." In addition, respondent applied cold compresses to the patient's body to decrease or control her fever.

January 17, 2004

10. (A) In the early morning of January 17, 2004, at 12:04 a.m., respondent began to administer Pitocin to the patient at a minimal rate to increase her contractions. The patient's temperature had decreased slightly to 102 degrees and she was having regular contractions about every four minutes for 60 seconds. Prior to administering the Pitocin, respondent failed to conduct a vaginal examination to discern the dilation of the patient's cervix. At 12.22 a.m., respondent stopped the Pitiocin for no apparent reason as documented in the medical or nursing record. The FHR was still tachycardic with a sinusoidal pattern. The FHR was fluctuating between 160 and 190.

(B) At 12:30 a.m., the patient complained of labor pain and requested an epidural. Respondent conducted a vaginal examination and discerned that the patient was dilated five centimeters. Her cervix was completely effaced. As such, the patient had progressed in her labor after being in the labor and delivery unit for two and one-half hours. Respondent contacted the anesthesiologist to request an epidural for the patient and started or continued an IV fluid bolus in preparation of the epidural.

(C) At 12:41 a.m., the patient's temperature had also dropped slightly to 101.6 degrees as respondent noted on the FHR monitoring strip. The FHR was still tachycardic with a sinusoidal pattern. The FHR baseline decreased to the range of 150 to 170. At 12:52 a.m., the FHR briefly decreased to 120 to 130. At 12:55 a.m., the fetus' heart rate began fluctuating between 100 and 150 for the next ten minutes or so. Tracing or monitoring of the FHR was not necessarily lost during this time period. Respondent did not verify or determine the reason for the changes in the fetal heart rate or tones before positioning the patient for the epidural.

11. (A) At 1:00 a.m., the anesthesiologist came to the labor and delivery room to administer the epidural. Respondent placed and helped hold the patient in a sitting position during the procedure which took approximately 23 minutes.

(B) When the epidural began, another nurse came into the labor and delivery room. The other nurse told respondent that she was calling Dr. Sohl and asked whether there was anything respondent wanted to tell him. Thus, at about 1:00 a.m., respondent told the other nurse to inform Dr. Sohl that the patient was five centimeters dilated and having an epidural and that respondent wanted him to come into the hospital to be at the patient's bedside. Respondent did not tell the other nurse to advise Dr. Sohl of the changes in the condition of the fetus.

(C) For the first three minutes of the epidural, the heart rate of the fetus fluctuated between 110 and 150. Thereafter, the FHR steadily decelerated or decreased to a baseline of 90 to 110 and then fell below 90. As such, during the 23-minute epidural, the FHR became bradycardic indicating that the fetus was experiencing distress. At the end of the procedure, the FHR tracing was lost. The patient's labor had become an emergency situation.

(D) During the epidural, respondent could not necessarily see the FHR monitoring strip because she was holding the patient but she could hear the fetal heart tones emitted by the monitor. Despite the falling heart rate of the fetus and fetal bradycardia, respondent failed to advise the anesthesiologist that the epidural should be stopped so that the fetus could be assessed. Respondent did not assess the status of the fetus.

12. Beginning at 1:23 a.m., respondent and the anesthesiologist began administering interventions to the patient to assist or resuscitate the fetus which had become bradycardic. Other nurses came into the labor room to help them. Respondent lowered the patient so that she was lying on her left side. The patient was given oxygen by a mask. Respondent performed a vaginal examination. When she was told that Dr. Sohl was not coming in until the patient's labor and dilation of her cervix had progressed further, respondent had another nurse call or page Dr. Sohl again to come into the hospital. A scalp electrode was applied to the head of the fetus in an attempt to discern the fetal heart rate. Fetal scalp stimulation was performed; the umbilical cord was not seen or palpated. The patient was placed in Trendelberg position and on her hands and knees. At 1:25 a.m., respondent had another nurse call Dr. Sohl again and had the operating room prepared for a Cesarean delivery. The patient's abdomen was shaved in preparation for the procedure.

13. At 1:40 a.m., the patient was taken to the operating room. Dr. Sohl arrived in the operating room while the patient was being prepared. Dr. Sohl immediately performed a Cesarean section and the fetus was delivered stillborn at 1:53 a.m. His operative findings were that fetal bradycardia occurred after placement of the epidural and the fetal heart rate did not return to normal. The preoperative and postoperative diagnoses were fetal bradycardia and non-reassuring fetal heart tracing. After her baby was delivered stillborn, the patient remained in the hospital for a few more days during which the blood and placenta

cultures showed that she was infected with Staphylococcus aureus. The patient was discharged after receiving treatment for her infection.

14. According to the medical chart, Dr. Sohl wrote that he received an initial call from respondent at 10:45 p.m. when the patient was admitted. He noted that he received a second call at 1:28 a.m. when he was asked to come into the hospital immediately for delivery. Dr. Sohl wrote that he received a third call within a few minutes thereafter in which the nurse clarified that it was patient A who was to deliver and not another patient that Dr. Sohl was thinking about. The nurse advised Dr. Sohl that the patient had an epidural and the fetus was now brachycardic.

15. Based on Findings 6 – 14 above, on January 16 and 17, 2004, while employed and on duty as a labor and delivery nurse at St. Mary hospital, respondent committed acts of gross negligence and incompetence in the care of patient A as follows:

a. Respondent administered Pitocin to the patient without first conducting a vaginal examination to assess the cervix and status of the patient's labor. Her unexplained termination of the administration of Pitocin after only 17 minutes and before the medication could become effective has a tendency in reason to demonstrate not only that respondent's administration of Pitocin was not medically indicated but also that her administration of Pitocin without assessment of the cervix constituted an extreme deviation from the standard of care and showed lack of skill or knowledge on her part.

b. Respondent failed to communicate accurate and complete information to the physician about the patient's condition and changes to her and her fetus' condition. After her initial call to the physician upon assessing the patient, respondent thereafter failed to advise the physician about the patient's rising temperature and changes to the baseline of the FHR when it became and remained tachycardic and then exhibited a sinusoidal and non-reassuring pattern. Respondent's failure to call and advise the physician constituted an extreme departure from the standard of care and showed a lack of requisite knowledge.

c. Respondent failed to interpret fetal monitoring data accurately and to take appropriate action. Soon after the admission of the patient, the FHR became tachycardic and remained tachycardic for most of the labor. After an hour, the FHR displayed a sinusoidal and non-reassuring pattern indicative of fetal distress. Respondent failed to interpret this FHR data and to conduct further assessments of the patient and fetus. She failed to contact the physician to advise him of changes to fetal heart tones and to have him come to the hospital earlier. Respondent's failures to interpret the fetal monitoring date accurately constituted an extreme departure from the standard of nursing care and constituted the failure to exercise the requisite degree of learning and skill possessed by a competent nurse.

d. Respondent failed to verify fetal heart tones before positioning the patient for the epidural. Before the start of the epidural, the fetal heart rate and/or tones had fluctuated and decreased which demonstrated a change in the condition and viability of the fetus. Respondent's failure to verify fetal heart tones and to assess the fetus in those

circumstances constituted extreme departures from the standard of care and showed a lack of nursing skill and knowledge.

e. Respondent failed to use the nursing chain of command when she was told after the epidural and during the emergency interventions that the physician was not coming into the hospital until the patient's labor had progressed further. In fact, respondent should have accessed the chain of command at the beginning of the epidural by asking the charge nurse or higher supervisory personnel to call the physician and inform him of the condition of the patient and fetus in order to ensure his prompt arrival at the hospital. Respondent's failure to use the nursing chain of command was an extreme departure from the standard of care and showed a lack of requisite knowledge.

16. (A) It was not established that respondent demonstrated gross negligence or incompetence when she administered Tylenol and started an intravenous line without first receiving orders from the physician. The administration of the Tylenol and start of the IV line were appropriate and within the standard of care for the patient's condition and her labor and delivery. Respondent anticipated that the physician would make these orders based on her experience and procedure at the hospital. In fact, the physician made orders for Tylenol and an IV line after respondent performed these nursing duties for the care of the patient.

(B) It was not established that respondent was grossly negligent or incompetent by failing to document the administration of the Tylenol in the patient's Medication Administration Record. Respondent charted the administration of the Tylenol in the nursing notes, FHR monitoring strip, and the labor and delivery flow sheet. After receiving the order for Tylenol from the physician, respondent documented the order in the physician orders.

(C) It was not established that respondent failed to adequately document the events of the patient's labor. No probative evidence was presented demonstrating that respondent's charting of the labor was inadequate, deficient, or below the standard of care. She charted the patient's labor in the medical record, nursing notes, labor flow sheet, and on the FHR monitoring strip. Her charting was adequate enough for the nursing experts in this matter to discern the course of the labor and to form opinions about respondent's actions. The problem in this matter was not necessarily charting but, instead, that respondent failed to properly interpret changes in the patient and fetus and to take appropriate action and communicate the changes to the physician.

(D) It was not established that respondent delayed the transfer of the patient to the operating room by continuing to perform interventions after the Cesarean section delivery was ordered. Nor was it established that respondent demonstrated gross negligence or incompetence in performing the interventions at the end of the epidural when the condition of the fetus became critical. The evidence showed that it was respondent who ordered the Cesarean section while she, the anesthesiologist, and other nurses jointly performed the interventions. The interventions occurred over a period of approximately 15 minutes and respondent had the patient transferred, prepared, and ready for the procedure by the time that

the physician arrived in the operating room. The Cesarean section did not occur earlier because respondent did not fully inform the physician of the condition of the fetus and the need for his presence at the hospital to perform the emergency delivery procedure.

(E) It was not established that respondent failed to use "proper nursing process" in the labor and delivery unit in "assessing, planning, intervening and evaluating the patient's condition and care." While complainant presented documentary evidence of fetal heart monitoring and the expert witness testified that respondent failed to follow the proper nursing process, no probative evidence was presented as to what was the "proper nursing process" in the circumstances of this matter. This allegation was taken almost verbatim from the last paragraph of the expert's written report and was not substantiated with evidence during the hearing.

17. (A) Respondent admits that she started an IV line, administered the Tylenol suppository, and inserted the Foley catheter into the patient's bladder for urinalysis without first receiving orders for these procedures from the physician. She indicates that she was following routine procedure in acting without physician orders.

(B) Respondent admits that she did not first consult with the physician or conduct a vaginal examination before administering Pitocin to the patient. She thought that the patient's cervix was appropriately dilated and presented with a good contraction pattern. However, respondent would perform a vaginal examination now before giving Pitocin to a patient.

(C) Respondent testified that she called Dr. Sohl at 10:45 p.m. and at 10:52 p.m. to advise that the patient had a fever and that the FHR had become tachycardic. Her testimony was not persuasive, for there are no notations in the nursing or medical record of any such additional communications. Respondent admits that the FHR was tachycardic beginning after 10:00 p.m. and continued to be so for much of the patient's labor. Based on what she has learned from this matter, she would now advise the physician whenever the patient has a fever and the FHR is tachycardic for over one hour.

(D) Respondent demonstrates remorse about her performance of her nursing duties in this matter as well as regret about the unfortunate outcome to the patient's baby. She recognizes that she has to be more assertive in emergent situations. She realizes that she should call the physician more frequently and to ask for help from nursing supervisors and staff. Here, by indicating that she would use a pulse oxymeter during an epidural to obtain and differentiate between the heart rate of the patient and the fetus, respondent impliedly admits that she did not recognize that the FHR had decelerated and become bradycardic. Respondent has also stated that she may have lost or been confused about the FHR while she was holding the patient during the epidural. However, the evidence showed fetal tracing was not lost and the FHR was audible from the FHR monitor.

18. (A) For the period from June 1, 2005, until May 31, 2006, respondent received a favorable annual review of her performance as a clinical labor and delivery nurse at St.

Mary Medical Center. She met or exceeded expectations in performing duties and responsibilities related to core values of the nursing unit. For example, respondent was dedicated to providing the highest quality of services and maintained composure when dealing with ambiguity or difficult times. She responded quickly and efficiently to the requests and needs of others and communicated effectively. She was found to have demonstrated knowledge of all applicable requirements of her job based on the scope of practice and performed her job in accordance with medical center policies, procedures, standards, and practices.

(B) With respect to her responsibilities in providing services, respondent was found to have performed priority or high risk procedures safely and within the scope of practice. She performed all procedures for assigned patients, identified actual and potential unsafe practices, and documented in accordance with hospital policy and procedure in timely manner, and sought appropriate assistance and consultation when unsure of her ability to perform safely and when performing unfamiliar skills or procedures.

(C) Regarding her specific duties in the labor and delivery unit, respondent was found to have demonstrated competence in applying the fetal monitor and evaluating fetal well being, communicated concerns to physicians and utilized the chain of command when appropriate, and demonstrated the ability to recognize abnormalities in the fetal strip and to implement corrective action. She demonstrated competence in the application of the fetal strip electrode and the administration of blood products. Her supervisor commented that respondent had shown improvement in her professional role as a labor and delivery nurse.

19. (A) In October 2003, respondent completed a six-hour continuing education class in neonatal resuscitation.

(B) In September 2005, respondent completed an eight-hour course in advanced fetal monitoring provided by Health Education Innovations.

(C) On December 14, 2006, respondent completed a MedTeams Training, four hour continuing education course presented by the Education Department of St. Mary Medical Center.

20. (A) Linda Scott, R.N., testified as a character witness on behalf respondent. Scott has been a registered nurse for 22 years and employed in the labor and delivery unit of St. Mary Medical Center for 19 years. She is a charge nurse in the unit during the day shift. She has known respondent for approximately nine years and supervised respondent during the day shift since her return to the unit. She has worked side-by-side with respondent at patients' bedsides. Scott attests that respondent is a dependable employee who helps other nurses when needed and works as a team member in the labor and delivery unit. Scott has received no complaints about respondent's care from any patients and would assign her to care for any high risk patients.

(B) Marie Thorpe is clinical nurse in the labor and delivery unit of St. Mary hospital. She has worked at the hospital for 14 years. She has known respondent for 14 years from their working together in the unit. Thorpe and respondent have helped each other in caring for patients and Thorpe has relieved respondent. Thorpe attests that respondent is a competent labor and delivery nurse. She has not noticed any problem or concern about respondent and has not received any complaint about her.

(C) Respondent submitted other letters of reference, which were admitted into evidence, attesting to her diligence, compassion, and honesty.

21. (A) The costs of enforcement of this matter came to the total sum of $19,917.25, as set forth in the Certification of Prosecution Costs (Exh. 4).

(B) The costs of investigation of this matter came to the total sum of $5,882.00, as set forth in the Declaration of Investigative Costs (Exh. 5).

(C) Additional reasonable costs of investigation and enforcement of this matter were the costs of the Board to retain an expert ($1,567.50) and the costs of a legal assistant team of $1,044.00, as set forth in the Certification of Costs of Investigation and Prosecution (Exh. 3).

* * * * * * *

Pursuant to the foregoing findings of fact, the Administrative Law Judge makes the following determination of issues:

LEGAL CONCLUSIONS

1. Grounds exist to revoke or suspend respondent's nurse's license for unprofessional conduct pursuant to Business and Professions Code section 2761, subdivision (a)(1), in that respondent committed gross negligence in carrying out the usual licensed nursing functions, as set forth in Findings 6 – 15 above. On January 16 and 17, 2004, respondent repeatedly failed to provide nursing care to a patient and fetus as required or failed to provide care or to exercise ordinary caution in a single situation which respondent knew, or should have known, could jeopardize the health or life of the patient and her fetus.

2. Grounds exist to revoke or suspend respondent's nurse's license for unprofessional conduct pursuant to Business and Professions Code section 2761, subdivision (a)(1), in that respondent demonstrated incompetence in carrying out usual licensed nursing functions, as set forth in Findings 6 – 15 above. On January 16 and 17, 2004, respondent committed acts or omissions demonstrating incompetence. Her acts or omissions showed the lack of possession or the failure to exercise the degree of learning, skill, care, and experience ordinarily possessed and exercised by a competent nurse. In violation of California Code of

Regulations, title 16, section 1443.5, respondent failed to formulate nursing diagnoses through the interpretation of information, including fetal monitoring data, obtained from the patient and fetus; failed to perform skills essential to the kind of nursing action to be taken; and failed to evaluate the effectiveness of the care plan through observation of the patient's and fetus' physical condition, signs and symptoms and reactions to treatment through communication with other health team members.

3. Grounds exist to direct respondent to pay a sum not to exceed the reasonable costs of investigation and enforcement of this matter pursuant to Business and Professions Code section 125.3 in that respondent has committed violations of the Nursing Practice Act, as set forth in Conclusions of Laws 1 and 2 and Finding 21 above. The reasonable costs of investigation and enforcement shall be deemed to be $15,000.00 based on the number of allegations of the Accusation that were proven, as set forth in Findings 15 and 16. In addition, it is observed that this matter involved largely the review of medical records in a single labor and delivery incident and the documentary evidence was not voluminous. Finally, the reduction of the costs will facilitate, rather than impede, the repayment by the licensee over the term of probation.

4. Discussion – Here, respondent's violations involved a single patient who came under her care near full-term in her pregnancy and with an undiagnosed temperature. Respondent treated this patient's case as a routine matter—she followed her customary practice in assessing the patient and then administering IV fluids as well as Tylenol for the fever without physician orders. She reported to the physician after about an hour following the patient's admission to the unit but did not express any concerns to the physician. Thereafter, she administered Ampicillin about an hour after receiving the order, gave the patient Pitocin without conducting a vaginal examination, and then approved the patient's request for an epidural.

The problem was that the patient's case was far from routine and became high risk soon after she came under respondent's nursing care. While she could not have known that the patient had a serious infection deleterious to the health of the fetus, respondent did not recognize and/or did not address the tachycardic fetal heart rate which became prolonged. Half an hour after respondent called the physician, the fetal heart rate became non-reassuring and showed a sinusoidal pattern indicative of possible fetal distress. The patient's fever and the fetus' tachycardia should have alerted respondent that the case was a high risk case. Respondent failed to tell the physician of the tachycardia or the subsequent change in the status of the fetus. Respondent did not properly assess the patient, who still had a fever, or the fetus on administration of the Pitocin and the epidural. The fetal heart rate remained tachycardic and sinusoidal. By the time that respondent decided to call the physician during the epidural, the fetal heart rate had become bradycardic and the fetus was in full distress. Even then, respondent failed to make clear to the physician the emergency nature of the delivery or to use the nursing chain of command to get the physician to the hospital as soon as possible.

Respondent recognizes that she did not handle this patient's care well. She demonstrates remorse for her unprofessional conduct. She admits that she would perform her nursing duties differently if faced with the same circumstances. She would call the physician earlier and more frequently. She has presented other important evidence of her rehabilitation. Respondent has been licensed as a registered nurse for eight years and has no prior disciplinary record. Her grossly negligent and incompetent conduct occurred over three years ago. Since then, she has been reinstated to her former employment as a labor and delivery nurse at St. Mary Medical Center, received a favorable review of work performance, and has had no further violations of the Nursing Practice Act. She has completed a course in advanced fetal monitoring and MedTeams Training. The charge nurse, who has supervised respondent since her return to the unit, attests that respondent is dependable and works as a team member. A colleague indicates respondent is a competent labor and delivery nurse. Character evidence shows respondent is diligent and honest. Based on Findings 1, 2, 4, and 16 – 20 above, respondent has established that she does not represent a risk to the public health and is an excellent candidate for a probationary license.

* * * * * * *

Wherefore, the following Order is hereby made:

ORDER

Registered nurse's license no. 555992 and licensing rights previously issued by the Board of Registered Nursing to respondent Maria Eugenia Collio are revoked, based on Conclusions of Laws Nos. 1 and 2, jointly and for all; provided, however, based on Conclusions of Law No. 4, said order of revocation is stayed and respondent's license is placed on probation for three (3) years on the following terms and conditions:

1. Obey All Laws - Respondent shall obey all federal, state and local laws. A full and detailed account of any and all violations of law shall be reported by the respondent to the Board in writing within seventy-two (72) hours of occurrence. To permit monitoring of compliance with this condition, respondent shall submit completed fingerprint forms and fingerprint fees within 45 days of the effective date of the decision, unless previously submitted as part of the licensure application process.

2. Comply With The Board's Probation Program - Respondent shall fully comply with the conditions of the Probation Program established by the Board and cooperate with representatives of the Board in its monitoring and investigation of the respondent's compliance with the Board's Probation Program. Respondent shall inform the Board in writing within no more than 15 days of any address change and shall at all times maintain an active, current license status with the Board, including during any period of suspension. Upon successful completion of probation, respondent's license shall be fully restored.

3. Report In Person - Respondent, during the period of probation, shall appear in person at interviews/ meetings as directed by the Board or its designated representatives.

4. Residency, Practice, or Licensure Outside of the State - Periods of residency or practice as a registered nurse outside of California shall not apply toward a reduction of this probation time period. Respondent's probation is tolled, if and when he or she resides outside of California. The respondent must provide written notice to the Board within 15 days of any change of residency or practice outside the state, and within 30 days prior to re-establishing residency or returning to practice in this state.

Respondent shall provide a list of all states and territories where he or she has ever been licensed as a registered nurse, vocational nurse, or practical nurse. Respondent shall further provide information regarding the status of each license and any changes in such license status during the term of probation. Respondent shall inform the Board if he/she applies for or obtains a new nursing license during the term of probation.

5. Submit Written Reports - Respondent, during the period of probation, shall submit or cause to be submitted such written reports/declarations and verification of actions under penalty of perjury, as required by the Board. These reports/declarations shall contain statements relative to respondent's compliance with all the conditions of the Board's Probation Program. Respondent shall immediately execute all release of information forms as may be required by the Board or its representatives.

Respondent shall provide a copy of this decision to the nursing regulatory agency in every state and territory in which he or she has a registered nurse license.

6. Function As A Registered Nurse - Respondent, during the period of probation, shall engage in the practice of registered nursing in California for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

For purposes of compliance with the section, "engage in the practice of registered nursing" may include, when approved by the Board, volunteer work as a registered nurse, or work in any non-direct patient care position that requires licensure as a registered nurse.

The Board may require that advanced practice nurses engage in advanced practice nursing for a minimum of 24 hours per week for 6 consecutive months or as determined by the Board.

If respondent has not complied with this condition during the probationary term, and the respondent has presented sufficient documentation of his or her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of the respondent's probation period up to one year without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation shall apply.

7. Employment Approval And Reporting Requirements - Respondent shall obtain prior approval from the Board before commencing or continuing any employment, paid or voluntary, as a registered nurse. Respondent shall cause to be submitted to the Board all performance evaluations and other employment related reports as a registered nurse upon request of the Board.

Respondent shall provide a copy of this decision to his or her employer and immediate supervisors prior to commencement of any nursing or other health care related employment.

In addition to the above, respondent shall notify the Board in writing within seventy-two (72) hours after he or she obtains any nursing or other health care related employment. Respondent shall notify the Board in writing within seventy-two (72) hours after he or she is terminated or separated, regardless of cause, from any nursing, or other health care related employment with a full explanation of the circumstances surrounding the termination or separation.

8. Supervision - Respondent shall obtain prior approval from the Board regarding respondent's level of supervision and/or collaboration before commencing or continuing any employment as a registered nurse, or education and training that includes patient care.

Respondent shall practice only under the direct supervision of a registered nurse in good standing (no current discipline) with the Board of Registered Nursing, unless alternative methods of supervision and/or collaboration (e.g., with an advanced practice nurse or physician) are approved.

Respondent's level of supervision and/or collaboration may include, but is not limited to the following:

a. Maximum - The individual providing supervision and/or collaboration is present in the patient care area or in any other work setting at all times.

b. Moderate - The individual providing supervision and/or collaboration is in the patient care unit or in any other work setting at least half the hours respondent works.

c. Minimum - The individual providing supervision and/or collaboration has person-to-person communication with respondent at least twice during each shift worked.

d. Home Health Care - If respondent is approved to work in the home health care setting, the individual providing supervision and/or collaboration shall have person-to-person communication with respondent as required by the Board each work day. Respondent shall maintain telephone or other telecommunication contact with the individual providing supervision and/or collaboration as required by the Board during each work day. The individual providing supervision and/or collaboration shall conduct, as required by the Board, periodic, on-site visits to patients' homes visited by the respondent with or without respondent present.

9. Employment Limitations - Respondent shall not work for a nurse's registry, in any private duty position as a registered nurse, a temporary nurse placement agency, a traveling nurse, or for an in-house nursing pool.

Respondent shall not work for a licensed home health agency as a visiting nurse unless the registered nursing supervision and other protections for home visits have been approved by the Board. Respondent shall not work in any other registered nursing occupation where home visits are required.

Respondent shall not work in any health care setting as a supervisor of registered nurses. The Board may additionally restrict respondent from supervising licensed vocational nurses and/or unlicensed assistive personnel on a case-by-case basis. Respondent shall not work as a faculty member in an approved school of nursing or as an instructor in a Board approved continuing education program. Respondent shall work only on a regularly assigned, identified and predetermined worksite(s) and shall not work in a float capacity.

If the respondent is working or intends to work in excess of 40 hours per week, the Board may request documentation to determine whether there should be restrictions on the hours of work.

10. Complete Nursing Courses – No later than six months prior to the end of her probationary term, respondent, at his or her own expense, shall enroll and successfully complete one course relevant to the practice of registered nursing.

In addition, no later than one year after the start of her probationary term, respondent shall enroll and successfully complete a second course in the area of assertiveness training. The Board may substitute another course nursing course if this type of course is not available.

Respondent shall obtain prior approval from the Board before enrolling in the course(s). Respondent shall submit to the Board the original transcripts or certificates of completion for the above required course(s). The Board shall return the original documents to respondent after photocopying them for its records.

11. Cost Recovery - Respondent shall pay to the Board costs associated with its investigation and enforcement pursuant to Business and Professions Code section 125.3 in the amount of $15,000.00. Respondent shall be permitted to pay these costs in a payment plan approved by the Board, with payments to be completed no later than three months prior to the end of the probation term.

If respondent has not complied with this condition during the probationary term, and respondent has presented sufficient documentation of his or her good faith efforts to comply with this condition, and if no other conditions have been violated, the Board, in its discretion, may grant an extension of the respondent's probation period up to one year

without further hearing in order to comply with this condition. During the one year extension, all original conditions of probation will apply.

12. Violation Of Probation - If respondent violates the conditions of her probation, the Board after giving the respondent notice and an opportunity to be heard, may set aside the stay order and impose the stayed discipline (revocation/suspension) of the respondent's license.

If during the period of probation, an accusation or petition to revoke probation has been filed against respondent's license or the Attorney General's Office has been requested to prepare an accusation or petition to revoke probation against the respondent's license, the probationary period shall automatically be extended and shall not expire until the accusation or petition has been acted upon by the Board.

13. License Surrender - During respondent's term of probation, if he or she ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the conditions of probation, respondent may surrender his or her license to the Board. The Board reserves the right to evaluate respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances, without further hearing. Upon formal acceptance of the tendered license and wall certificate, respondent will no longer be subject to the conditions of probation.

Surrender of respondent's license shall be considered a disciplinary action and shall become a part of respondent's license history with the Board. A registered nurse whose license has been surrendered may petition the Board for reinstatement no sooner than the following minimum periods from the effective date of the disciplinary decision:

a. Two years for reinstatement of a license that was surrendered for any reason other than a mental or physical illness; or

b. One year for a license surrendered for a mental or physical illness.

14. Severability Clause – Each condition of probation contained herein is a separate and distinct condition. If any condition of this Order, or any application thereof, is declared unenforceable in whole, in part, or to any extent, the remainder of this Order, and all other applications thereof, shall not be affected. Each condition of this Order shall separately be valid and enforceable to the fullest extent permitted by law.

Dated: June 20, 2007

Vincent Nafarrete
Administrative Law Judge
Office of Administrative Hearings

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Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: MARIA EUGENIA COLLIO 2161 25th St., Apt. 11 San Pedro, CA 90732 Registered Nurse License No. 555992 Respondent.	Case No. 2006-222 **ACCUSATION**

Complainant alleges:

PARTIES

1. Ruth Ann Terry, M.P.H., R.N. (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about June 23, 1999, the Board of Registered Nursing issued Registered Nurse License No. 555992 to Maria Eugenia Collio (Respondent). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2007, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing

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(Board), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

STATUTORY PROVISIONS

4. Section 2750 of the Business and Professions Code (Code) provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license. Under Code section 2811, subdivision (b), the Board may renew an expired license at any time within eight years after the expiration.

6. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession

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of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

9. California Code of Regulations, title 16, section 1443.5 states:

"A registered nurse shall be considered to be competent when he/she consistently demonstrates the ability to transfer scientific knowledge from social, biological and physical sciences in applying the nursing process, as follows:

"(1) Formulates a nursing diagnosis through observation of the client's physical condition and behavior, and through interpretation of information obtained from the client and others, including the health team.

"(2) Formulates a care plan, in collaboration with the client, which ensures that direct and indirect nursing care services provide for the client's safety, comfort, hygiene, and protection, and for disease prevention and restorative measures.

"(3) Performs skills essential to the kind of nursing action to be taken, explains the health treatment to the client and family and teaches the client and family how to care for the client's health needs.

"(4) Delegates tasks to subordinates based on the legal scopes of practice of the subordinates and on the preparation and capability needed in the tasks to be delegated, and effectively supervises nursing care being given by subordinates.

"(5) Evaluates the effectiveness of the care plan through observation of the client's physical condition and behavior, signs and symptoms of illness, and reactions to treatment and through communication with the client and health team members, and modifies the plan as needed.

"(6) Acts as the client's advocate, as circumstances require, by initiating action to improve health care or to change decisions or activities which are against the interests or wishes of the client, and by giving the client the opportunity to make informed decisions about health care before it is provided."

10. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or

violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

Patient A.

11. On or about January 17, 2004, respondent was working in the Labor and Delivery Unit (L & D) at St. Mary Medical Center (SMMC), in Long Beach, California. Respondent was assigned to Patient A. who was admitted to the L & D unit at approximately 2200 hours in early labor. The patient had a 98.8 degree temperature, spontaneously ruptured membranes, and a fetal heart rate (FHR) of 140-150 beats per minute (bpm). At approximately 2230 hours respondent documented the FHR at 150-160 bpm with average long term variability (LTV) but failed to identify late decelerations. At approximately 2300 hours, respondent charted Patient A's temperature at 102 degrees, medicated the patient with a Tylenol suppository and started intravenous medication without first notifying the patient's physician of the patient's condition.

At approximately 2330 hours the FHR increased to190-200 bpm. Respondent failed to recognize the minimal long-term variability (LTV) followed by a sinusoidal pattern. Respondent should have notified Patient A's physician of this change in maternal-fetal status. At 2400 hours respondent documented that patient A's temperature remained elevated at 103.0 degrees. But respondent misinterpreted the sinusoidal pattern as acceleration and tachycardia and again failed to notify Patient A's physician of the change in maternal-fetal status.

On January 18, 2004, at approximately 0004 hours, without evaluating the labor status in terms of cervical change, respondent started administering Pitocin to the patient to accelerate her labor. Pitocin was not indicated for the pattern of uterine contractions recorded. Respondent discontinued the Pitocin approximately 17 minutes later. At approximately 0030 respondent charted that the patient's temperature had decreased to 101.6 degrees, that the patient was dilated to 5cm, and that the patient had requested an epidural. At approximately 0100, respondent asked another nurse to call the patient's doctor and ask him to come in to the hospital because the patient was dilated to 5 cm and was having an epidural. But respondent did not ask the other nurse to advise the doctor that the patient's temperature was elevated or that the FHR

was decelerating. When the doctor declined to come in to the hospital, respondent took no steps to initiate the chain of command to secure the physician's attendance.

At approximately 0100 hours respondent proceeded to place Patient A. in a sitting position for an epidural anesthetic while the fetus was demonstrating variable decelerations and the FHR was decreasing to 100 to 90 bpm. The FHR continued decelerating to 80 bpm for approximately 18 minutes while the epidural as being placed. Respondent charted that the epidural was done at 0120 hours and that fetal bradycardia was noted. The standard of care is to assess the FHR at 15 minute intervals. The FHR indicated a non-reassuring pattern. Respondent breached her duty to ask the anesthesiologist to pause in her attempts to place the epidural so that respondent could appropriately assess the FHR. In addition, although respondent changed the patient's position after the epidural was inserted to try to alleviate the non-reassuring FHR pattern, she failed to make any attempt to assess the source of fetal bradycardia.

At 0131 hours, Patient A's physician arrived at her bedside, and ordered the patient taken to the operating room. Respondent continued deceleration intervention even after the physician had called for the C-section, delaying the patient's arrival in the operating room until 0140 hours. The FHR had decelerated to 60-70 bpm. At 0153 hours the infant was delivered by cesarean section. The infant was stillborn.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence and/or Incompetence)

12. Respondent is subject to disciplinary action under section 2761, subdivision (a)(1), for unprofessional conduct as defined in California Code of Regulations, title 16, sections 1442, 1443 and 1443.5, in that on or about January 17, 2004, while employed and on duty as a registered nurse, she committed acts of gross negligence and/or incompetence, as follows:

a. Respondent administered Tylenol and started an intravenous line without a physician's order.

b. Failed to document the administration of the Tylenol on the patient's Medication Administration Record.

c. Administered Pitocin without prior assessment of the cervix.

d. Failed to verify fetal heart tones before positioning the patient for an epidural anesthetic.

e. Failed to communicate accurate and complete information about Patient A's condition to the patient's physician.

f. Failed to use chain of command when told the physician was not coming to the hospital.

g. Failed to use proper nursing process in the L & D unit in assessing, planning, intervening and evaluating the patient's condition and care.

h. Failed to interpret fetal monitoring data accurately and take appropriate action.

i. Failed to communicate changes in the condition of the patient to the patient's physician. Since there was a change in maternal-fetal status, Patient A.'s physician should have been notified.

j. Failed to adequately document the events of the labor, especially the interpretation of fetal monitoring data.

k. Delayed the patient's transfer to the operating room by continuing deceleration intervention after a C-section was ordered.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 555992, issued to Maria Eugenia Collio;

2. Ordering Maria Eugenia Collio to pay the Board of Registered Nursing the

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reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and

3. Taking such other and further action as deemed necessary and proper.

DATED: 5/15/06

RUTH ANN TERRY, M.P.H., R.N.
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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